EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

_____ _____

Date Patient Name

_____ _____

Personal Physician Patient Address

_____

Framingham Heart Study
Cohort Exam 24

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

_____

The following tests are done on a routine basis:; Blood Glucose; Blood Lipids;
Only abnormal findings will be forwarded at a later date

Summary of Findings_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Examiner
Framingham Heart Study
National Heart, Lung, and Blood Institute
National Institutes of Health
5 Thurber Street
Framingham, MA 01701

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Numerical Data--Part I

240201 FORM NUMBER VERSION 7-19-96

Basic Information	
|__|	**Site of Exam** (0=Heart Study,1=Nursing home,2=Residence, 3=Other)
If 0 skip down If 1 or 2 fill ☞	|__| **Nursing Home Level of Care 0**=None; **1**=Skilled care 24hrs, **2**=Skilled care 8-16 hrs; **3**=Self care**; 9**=unknown
|__|	**Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)
|__|__|	**Examiner's Number** (99= unknown)
|__|__|__|	**Weight** (to nearest pound) (99= unknown)
|__|__|*|__|__|	**Height** (inches, to next lower 1/4 inch) (99= unknown)

|__| **Proxy used to complete this exam (0=No, 1=Yes, 9=Unk)**

If yes, fill☞

Proxy Name _____

|__| **Relationship** (1= 1st Degree Relative(spouse, child), 2= Other relative, 3= Friend 4= Health Care Professional, 5= Other, 9= Unknown)

|__||__| |__||__| **How long have you known the participant?** (Years, Months)

|__| **Are you currently living in the same household with the participant?** (0=No,1=Yes)

|__| **How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=once a week, 4=1 to 3 times per month, 5= less than once a month, 9=unknown/N/A)

	Systolic	Diastolic	Examiner ID
Examiner Blood Pressure (first reading)	|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg	Prefix |__| 0=MD, 1=Other ID |__|__|__|

	Systolic	Diastolic	Examiner ID
Examiner Blood Pressure (second reading)	|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg	Prefix |__| 0=MD, 1=Other ID |__|__|__|

Exam 24 Procedures Sheet	
|__|	**Blood Lipids**
|__|	**ECG Done**

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Sentence and Design Handout for Patient

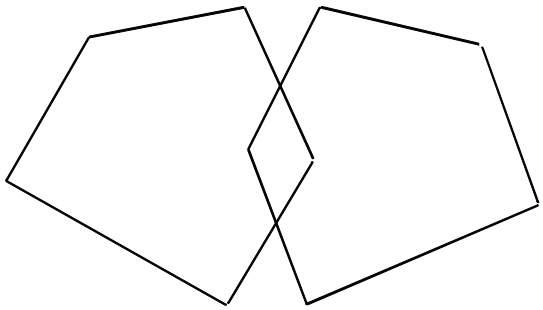
PLEASE WRITE A SENTENCE

_____

_____

_____

PLEASE COPY THIS DESIGN



EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Cognitive Function--Part I

240203 FORM NUMBER VERSION 12/7/95

|__|-----|__|__|__| (0=MD,1=Other)	**Examiner's Number**

SCORE CORRECT No Try=6 Unknown=9	**Write all responses on exam form.**
0 1 2 3 6 9	**What Is the Date Today?** (Month, day, year, correct score=3)
0 1 6 9	**What Is the Season?**
0 1 6 9	**What Day of the Week Is it?**
0 1 2 3 6 9	**What Town, County and State Are We in?**
0 1 6 9	**What Is the Name of this Place?** (any appropriate answer all right, for instance my home, street address, heart study ..max score=1)
0 1 6 9	**What Floor of the Building Are We on?**
0 1 2 3 6 9	**I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple,Table, Penny**
|__|__|__|__|__|	**Now I am going to spell a word forward and I want you to spell if backwards. The word is world. WO-R-L-D. Please Spell it in Reverse Order. Write in Letters,_____** (Letters Are Entered and Scored Later)
0 1 2 3 6 9	**What are the 3 objects I asked you to remember a few moments ago?**

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Cognitive Function --Part II

240204 FORM NUMBER

|__|-----|__|__|__|	**Examiner's Number**

SCORE CORRECT **No Try=6 Unknown=9**	**Write all responses on exam form.**
0 1 6 9	**What Is this Called?** (Watch)
0 1 6 9	**What Is this Called?** (Pencil)
0 1 6 9	**Please Repeat the Following: "No Ifs, Ands, or Buts."** (Perfect=1)
0 1 6 9	**Please Read the Following & Do What it Says** (performed=1, code 6 if low vision)
0 1 6 9	**Please Write a Sentence** (code 6 if low vision)
0 1 6 9	**Please Copy this Drawing** (code 6 if low vision)
0 1 2 3 6 9	**Take this piece of paper in your right hand, fold it in half with both hands, and put it in your lap** (score 1 for each correctly performed act, code 6 if low vision)
No Yes Maybe Unk (coding below)	**Factors Potentially affecting Mental Status Testing**
0 1 2 9	**Illiteracy or low education**
0 1 2 9	**Not fluent in English,**
0 1 2 9	**Poor Eyesight**
0 1 2 9	**Poor Hearing**
0 1 2 9	**Depression**
0 1 2 9	**Aphasia**
0 1 2 9	**Coma**
0 1 2 9	**Parkinsonism**
0 1 2 9	**Other**

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Activities of Daily Living

240205 FORM NUMBER

|__|-----|__|__|__|	**Examiner's Number**

During the Course of a Normal Day, How Do You Carry out the Following Activities? Coding: 0=No help needed, independent, 1=Uses device,independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown	
|__|	**Dressing** (undressing and redressing)
|__|	**Bathing** (including getting in and out of tub or shower)
|__|	**Eating**
|__|	**Transferring** (getting in and out of a chair)
|__|	**Toileting Activities** (using bathroom facilities and handle clothing)
|__|	**Bladder Continence** (ask if person has "accidents") (code=5 if use special products)
|__|	**Bowel Continence** (ask if person has "accidents") (code=5 if use special products)
|__|	**Walking on Level Surface about 50 Yards** (length of Thurber St.)
|__|	**Walking up and down One Flight Stairs**
|__|	**Using a Telephone**
|__|	**Taking Own Medications** (code as above, and 8=takes no medications regularly)

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Activities--Part II

2402052 FORM NUMBER

|__| **Are you in bed or in a chair for most or all of the day (on the average)?**
(Note: this is a lifestyle question, not due to health) (0=No, 1=Yes, 9=Unk or Not sure)

|__| **Do you need a special aid (wheelchair, cane, walker) to get around?**
(0=No; 1=Yes,always; 2=Yes,sometimes; 9=Unknown)

|__| **If use a special aid,which of the following equipment do you use?**
(0=No, 1=Yes,always; 2=Yes,sometimes; 9=Unknown) if yes, note below

|__| **Cane or walking stick**

|__| **Wheelchair**

|__| **Walker**

|__| **Other (Write in)_____**

|__| **Are you working now:** (0=No, 1=Yes,Full time, 2=Yes, Part time, 9=Unknown)

|__|__|_ | **During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities?** (999=Unknown)

(Codes for Next 6 Questions: (0=No,Unable to do; 1=Yes,Independent;
2=Yes, with Human Assistance; 9=Unknown)

|__| **Are you able to do heavy work around the house, like shovel snow or wash windows, walls or floors without help?**

|__| **Are you able to walk up and down stairs to the second floor without any help?**

|__| **Are you able to walk a mile without help?** (About 8 blocks)

|__| **If you had to, could you do all the housekeeping yourself? (like washing clothes and cleaning)?**

|__| **If you had to, could you do all the cooking yourself?**

|__| **If you had to, could you do all the grocery shopping yourself?**

|__| **Do you drive?** (0=No, 1=Yes,currently, 2=Yes, not now, 9=Unk)

|__| **Reason for not driving now**
(1=Health, 2=Other non-health reason, 3=Never licensed, 8=N/A, current driver, 9=Unknown)

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Activities--Part III

2402053 FORM NUMBER

For each activity that subject had a lot of difficulty doing or was unable to do (codes 3 or 4), ask for reason(s)

For each thing tell me whether you have
(0) No difficulty
(1) A little difficulty
(2) Some difficulty
(3) **A lot of difficulty--give reasons**
(4) **Unable to do--give reasons**
(5) Don't do on MD orders
(9) Unknown

|__| Pulling or pushing large objects like a living room chair.
If code 3 or 4, give reason_____

|__| Either stooping, crouching, or kneeling
If code 3 or 4, give reason_____

|__| Reaching or extending arms below shoulder level
If code 3 or 4, give reason_____

|__| Reaching or extending arms above shoulder level
If code 3 or 4, give reason_____

|__| Either writing, handling, or fingering small objects.
If code 3 or 4, give reason_____

|__| Standing in one place for long periods, say 15 minutes
If code 3 or 4, give reason _____

|__| Sitting for long periods, say 1 hour
If code 3 or 4, give reason_____

|__| Lifting a 10 pound object off the floor (sack of potatoes)
If code 3 or 4, give reason_____

|__| Walking one half a mile (4-6 blocks)
If code 3 or 4, give reason_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Functional Performance

240206 FORM NUMBER

|__|---|__|__| __|	**Examiner's Number**

Basic Functions

|__|	**Where do you live:** (0 = Private Residence, 1 = Nursing home, 2 = Other institution, such as: home-self care retirement village, 9=Unknown)
|__|	**Does anyone live with you**: (0=No, 1=Yes, 9=Unknown) (Code Nursing Home Residents as NO to these questions)

If Yes ☞

If 0 or 9 skip down

0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Spouse
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Significant Other
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Children
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Friends
0=No	1=Yes < 3 mo/yr	2=Yes ≥3 mo/yr	9=Unk	Relatives

	**** Proxy may not be used to help complete this section** **
|__|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor,9=Unkn)
|__|	**Compare your health to most people your own age:** (1=Better, 2=About the same, 3=Worse, than most people your own age, 9=Unknown)

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Falls and Fractures

240207 FORM NUMBER

|__| **In the past year have you accidentally fallen and hit the floor or ground?**
(code as no if during sports activity) (0=no, 1=Yes, 2=Maybe, 9=Unknown)

If yes or maybe fill ☞ and below

|__|__| **How many times did you fall in the past year?** (88=N/A, 99=Unk

Did any of your falls in the past year result in a:
(Code: 0=No, 1=Yes, 2=Maybe, 8=N/A, 9=Unknown

|__| **Fracture**

|__| **Head injury requiring medical attention**

|__| **Dislocation**

|__| **Bruise, sprain, or cut**

|__| **Other** (write in)_____

Fractures

|__| **Since Your Last Clinic Visit Have You Broken Any Bones?**
(Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown)

If 0 or 9 then skip rest of table

If 1,2, fill ☞

Left	Right	Location(code unknown as 00)
19|__|__|	19|__|__|	**Upper arm (humerus) or elbow**
19|__|__|	19|__|__|	**Forearm or wrist**
19|__|__|		**Back** (If disc disease only, code as no)
19|__|__|		**Pelvis**
19|__|__|	19|__|__|	**Hip**
19|__|__|		**Other** (specify)_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Hospitalizations

VERSION 12/7/95 COHORT EXAM 24
240301 FORM NUMBER (SCREEN 1)

|__|-----|__|__|__| (0=MD, 1=Other)	**First Examiner's Number** _____ First Examiner Name

DATE _____

Basic Background and Health Care

|__|	**Hospitalization (not just E.R.) in Interim** (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
|__|	**E.R. Visit in Interim** (0=No; 1=Yes, 1 visit, 2=Yes,more than 1 visit 9=Unk)
|__|	**Day Surgery** (0=No, 1=Yes, 9=Unknown)
|__|	**Illness with visit to doctor** (0=No, 1=Yes,1 visit; 2=Yes,more than 1 visit; 9=Unk)
|__|	**Check up** in interim by doctor (0=No, 1=Yes, 9=Unknown)
_____ MM DD YY	**Date** of this FHS exam (Today's date - See above)

Medical Encounter	Month/Year (of last visit)	Site of Hospital or Office	Doctor

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Cardiovascular Medications

240302 FORM NUMBER (SCREEN 2)

|__|	**Take aspirin regularly** (0=No, 1=Yes, 9=Unk)
If yes,	|__|__|	**Number aspirins taken regularly** (99=Unknown)
fill☞	|__|	**Aspirin frequency**- number taken regularly (0=Never, 1=Day, 2=Week ,3=Month, 4=Year, 9=Unk)
	|__|__|__|	**Usual aspirin dose for above** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk
|__|	**Currently receiving medication for the treatment of hypertension?** (0=No,1=Yes,9=Unk)
|__| **If yes,continue**	**Any of the cardiovascular medications below on this page?** (0=No, 1=Yes, 9=Unk)

|__|	**Cardiac Glycosides**	CODE 0=No; 1=Yes,now; 2=Yes,not now 3=Maybe, 9=Unknown)
|__|	**Nitroglycerine**	
|__|	**Longer acting nitrates** (Isordil, Cardilate, etc.)	
|__|	**Calcium Channel Blockers** (Nifedipine, Verapamil, Diltiazem)	
if yes, fill☞	|__|	**Short or long acting** (0=none, 1=short, 2=long, 9=unk)	
|__|	**Beta Blockers** (0=No, 1=Yes, 2=Yes, not now, 3=maybe, 9=Unk) (Specify_____	
if yes fill ☞ and continue	|__|	**Beta Blocker Group** (Propranolol=01 Timolol =02 Nadolol=03 Atenolol=04 Metoprolol=05 Pindolol =06 Acebutolol=07 Labetalol=08 Other=09)	
	|__|__|__|	**Dose** (mg/day) of Beta Blocker (999=unknown)	
|__|	**Loop Diuretics** (Lasix, etc.)	CODING FOR REST OF PAGE 0=No; 1=Yes,now;2=Yes,not now 3=Maybe,9=Unknown)
|__|	**Thiazide/K-sparing diuretics**(Dyazide, Maxide, etc.)	
|__|	**Thiazide diuretics**	
|__|	**K-sparing diuretics** (Aldactone, Triamterene)	
|__|	**Potassium supplements**	
|__|	**Reserpine** derivatives	**All Medicines-- Scratch Sheet**
|__|	**Methyldopa** (Aldomet)	_____
|__|	**Alpha-1 agonist** (Clonidine, Wytensin, Guanabenz)	_____
|__|	**Alpha-2 blockers** (Prazosin, Terazosin, Doxazosin)	_____
|__|	**Renin-angiotensin blocking drugs (ACE)** (Captopril, Enalapril, Lisinopril)	_____
|__|	**Peripheral vasodilators** (Hydralazine, Minoxidil, etc)	_____
|__|	**Other anti-hypertensives**(Specify)_____	_____
|__|	**Antiarrhythmics** (Quinidine, Procainamide, Norpace,Disopyramide,etc)	
|__|	**Antiplatelet** (Anturane, Persantine, etc.)	
|__|	**Anticoagulants** (Coumadin, Warfarin, etc.)	
|__|	**Other cardiac medication** (Specify)_____	

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner -- Other Medications

240303 FORM NUMBER (SCREEN 3)

|__|	**Anti cholesterol drugs** (Resins--e.g. Questran, Colestid)
|__|	**Anti cholesterol drugs** (Niacin or Nicotinic Acid)
|__|	**Anti cholesterol drugs** (Fibrates--e.g. Gemfibrozil)
|__|	**Anti cholesterol drugs** (Statins--e.g.Lovastatin,Pravastatin)
|__|	**Anti cholesterol drugs** (Other--Specify_____)
|__|	**Antigout--uric acid lowering** (Allopurinol, Probenecid etc)
|__|	**Antigout**--(Colchicine)
|__|	**Thyroid extract** (Dessicated Thyroid)
|__|	**Thyroxine** (Synthroid etc.)
|__| **if yes fill in dose** ☞	**Insulin** 0=No, 1=Yes,now 2=Yes,not now 3=Maybe 9=Unknown |__|__|__| Total units of insulin a day
|__|	**Oral hypoglycemics** (Specify brand_____)
|__|	**Oral/patch estrogen** (for women users also see estrogen section)
|__|	**Oral glucocorticoids** (Prednisone, Cortisone,etc)
|__|	**Non-steroidal anti-inflammatory agents (NSAIDS)** (Motrin,Ibuprofen, Naprosyn, Indocin, Clinoril)
|__|	**Analgesic-narcotics** (Demerol, Codeine, Dilaudid, etc.)
|__|	**Analgesic-non-narcotics** (Acetaminophen etc.)
|__|	**Antihistamines**
|__|	**Antiulcer** (Tagamet, Ranitidine, Probanthine, H ion inhibitors)
|__|	**Anti-anxiety, Sedative/Hypnotics** etc. (Librium, Valium etc.)
|__|	**Sleeping pills**
|__|	**Anti-depressants**
|__|	**Eyedrops**
|__|	**Antibiotics**
|__|	**Anti-parkinson drugs** (Sinemet, L-Dopa, Symmetrel, Cogentin, etc)
|__|	**Anticonvulsants** (Dilantin, Phenobarbital, Tegretol, Mysoline etc)
|__|	**Bronchodilators and aerosols**
|__|	**Others** Specify:_____

CODING FOR REST OF PAGE

0=No

1=Yes,now

2=Yes,not now

3=Maybe

9=Unknown

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Genitourinary and Thyroid Disease

240304 FORM NUMBER (SCREEN 4)

Female Genitourinary

|__| **Estrogen replacement in interim** (e.g. Premarin)
(0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)

If yes, fill all to ☞

|__| **Dose/day of premarin conjugated Estrogens, or other oral estrogen**
(0=No, 1=0.3 mg, 2=0.625 mg, 3=1.25 mg, 4=2.5mg,, (pick nearest dose)
5=other_____ 9=Unk)
(write in)

|__| **Patch dose of estrogen** (0=No, 1=0.5 mg/wk, 2=other _____, 9=Unk)
(write in)

|__|__| **Number of days a month taking estrogens** (99=Unknown)

|__| **Progesterone use interim (0=No, 1=Yes,now; 2=Yes,not now, 8=Man, 9=Unk)**

Male Genitourinary Disease

|__| **Prostate trouble in interim** **(0=No, 1=Yes,now; 2=Yes,not now, 8=Woman, 9=Unk)**

|__| **Prostate surgery in interim**

Medical History-- Thyroid

|__| **Interim diagnosis of a thyroid condition?**(0=No,1=Yes,9=Unknown)

Comments_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Smoking and Respiratory

240305 FORM NUMBER (SCREEN 5)

|__|	**Smoked cigarettes regularly in the last year?** **(0=No, 1=Yes, 9=Unkown)**	
if yes fill rest of this table	|__|__|	How many cigarettes do/did you smoke a day? (01=one or less, 99=unknown)

Respiratory Symptoms

\|__\| **Chronic cough in interim** (at least 3 months/year)
(0=No; 1=Yes, productive; 2=Yes, non-productive; 9=Unknown)

if yes, ☞ \|__\| Type of Cough (1=New in interim, 2=Old, 9=Unknown)

\|__\| **Wheezing or asthma** (0=No, 1=Yes, 9=Unknown)

\|__\| **Dyspnea on exertion**
(0=No)
(1=Climbing stairs or vigorous exertion)
(2=Rapid walking or moderate exertion)
(3=Any slight exertion)
(9=Unknown)

if yes, ☞ \|__\| **Dyspnea has increased over the past two years** (0=No, 1=Yes, 9=Unk)

\|__\| **Orthopnea**
\|__\| **Paroxysmal nocturnal dyspnea**
\|__\| **Ankle edema bilaterally**

(0=No, 1=Yes-new in interim, 2=Yes-old complaint, 9=Unknown)

Respiratory Comments _____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner -- Heart and Cerebrovascular

240306 FORM NUMBER (SCREEN 6)

|__|	**Any chest discomfort since last exam**	**(0=No, 1=Yes,2=Maybe,9=Unknown)**	
if yes, fill☞ and below	|__|	Chest discomfort with exertion or excitement	(0=No, 1=Yes,2=Maybe,9=Unknown)
	|__|	Chest discomfort when quiet or resting	
	|__|	Seen MD for above	
	|__|	Been hospitalized for above	

Syncope

\|__\| **Have you fainted or lost consciousness in the interim?** Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
(If due to stroke code as no and skip to cerebrovascular section)
If event immediately preceded by head injury or accident code 0=No)

Cerebrovascular Episodes in Interim

\|__\| **Stroke**

Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown

\|__\| **Mini-stroke or transient ischemic attack (TIA)**

\|__\| **CT or MRI scan (head) since last exam** (date/place_____)

\|__\| **Seen by neurologist since last exam** (write in who and when below): 0=No, 1=Yes,2=Maybe, 9=Unknown

_____

Neurology Comments_____

_____

_____

_____

_____

_____

_____

_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Peripheral Arterial and Venous

240307 FORM NUMBER (SCREEN 7)

0= Able	**1=Needs help**	**2= Can't Walk**	**9=Unkn**	**Can you walk 50 feet without help?** (e.g. no cane, walker, wheelchair) (0=Able to walk 50 feet without help,1=Needs help, 2=Can't Wak 9=Unk)
0= No	**1=Yes**	**2= Can't Walk**	**9=Unkn**	**Do you have cramping in calves or thighs while walking?** (0=No, 1=Yes, 2= Can't Walk 9=Unkn)
0= No	**1=Yes**		**9=Unkn**	**Have you been tested for cramping in calves or thighs?** (0=No, 1=Yes, 9=Unkn) if yes, give details_____ _____ ___

Comments Peripheral Vascular Disease_____

_____

_____

_____

_____

_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner -- CHD and Complications

240308 FORM NUMBER (SCREEN 8)

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	**Cardiovascular Procedure (in the interim only, not lifetime)**
|__| **if yes fill☞**	**Exercise Tolerance Test (most recent only)**
	19|__|__| Year done Location_____
|__| **if yes fill ☞**	**Coronary arteriogram (most recent only)**
	19|__|__|Year done (99=unknown)
|__| **if yes fill☞**	**Coronary artery angioplasty**
	19|__|__| Year first done (99=unknown)
	|__| Type of procedure (0=none, 1=balloon, 2=other_____ 9=unkn),
|__| **if yes fill☞**	**Coronary bypass surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Permanent pacemaker insertion**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Carotid artery surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Thoracic aorta surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Abdominal aorta surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Femoral or lower extremity surgery**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Lower extremity amputation**
	19|__|__| Year first done (99=unknown)
|__| **if yes fill ☞**	**Valve surgery**
	19|__|__| Year first done (99=unknown) Type _____

Cardiovascular Procedures Interim Summary
Please list all subsequent cardiovascular procedures

Date	Hospital	Type of Procedure
___/___/____		
___/___/____		
___/___/____		
___/___/____		

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner - Cancer Site or Type

240309 FORM NUMBER (SCREEN 9)

|__| **Have you, since your last clinic visit, had cancer or a tumor? (0=No and skip to next screen, If 1=Yes, 2=Maybe, 9=Unknown please continue)**

Code for table: 0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=Benign, 9=Unknown

Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
|__|	**Esophagus**			
|__|	**Stomach**			
|__|	**Colon**			
|__|	**Rectum**			
|__|	**Pancreas**			
|__|	**Larynx**			
|__|	**Trachea/Bronchus/Lung**			
|__|	**Leukemia**			
|__|	**Skin**			
|__|	**Breast**			
|__|	**Cervix/Uterus**			
|__|	**Ovary**			
|__|	**Prostate**			
|__|	**Bladder**			
|__|	**Kidney**			
|__|	**Brain**			
|__|	**Lymphoma**			
|__|	**Other/Unknown** _____			

Comment (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, treatments)

_____

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EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

First Examiner --Items needing Second Opinion

240310 FORM NUMBER (SCREEN 10)

Coronary Heart Disease First Examiner Opinions (Medical Assistant)		
|__|	**Possible Heart Disease in Interim (angina, MI, valvular disease, CHF)**	0=No,
|__|	**Possible Syncope in Interim**	1=Yes,
|__|	**Possible Cerebrovascular Disease in Interim (stroke, TIA, other)**	2=Maybe,
|__|	**Possible Peripheral Vascular Disease in Interim**	9=Unknown

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner ---Electrocardiograph Part I

240311 FORM NUMBER (SCREEN 11)

|__|----|__|__|__| (0=MD, 1=Other)	**2nd Examiner ID Number**	_____**2nd Examiner Last Name**

|__| if Yes, fill out rest of form	**ECG done** (0=No, 1=Yes)
	Rates and Intervals
|__|__|__|	**Ventricular rate per minute** (999=Unknown)
|__|__|	**P-R Interval** (hundreths of a second) (99=FullyPaced, Atrial Fib, or Unknown)
|__|__|	**QRS interval** (hundreths of second) (99=Fully Paced, Unknown)
|__|__|	**Q-T interval** (hundreths of second) (99=Fully Paced, Unknown)
|__|__|__|__|	**QRS angle** (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)
	Rhythm
|__|	0 or 1 = Normal sinus,(including s.tach, s.brady, s arrhy, 1 degree AV block) 3 = 2nd degree AV block, Mobitz I (Wenckebach) 4 = 2nd degree AV block, Mobitz II 5 = 3rd degree AV block / AV dissociation 6 = Atrial fibrillation / atrial flutter 7 = Nodal 8 = Paced 9 = Other or combination of above (list)_____
	Ventricular conduction abnormalities
|__|	IV Block (0=No, 1=Yes, 9=Fully paced or Unknown)
if yes, fill to right	|__| Pattern (1=Left, 2=Right, 3=Indeterminate)
	|__| Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)
	|__| Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)
|__|	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
|__|	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
	Arrhythmias
|__|	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
|__|	Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
|__|__|	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip)

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner -Electrocardiograph Part II

240312 FORM NUMBER (SCREEN 12)

Myocardial Infarction Location

(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)

|__| Anterior

|__| Inferior

|__| True Posterior

Left Ventricular Hypertrophy Criteria

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

|__| R > 20mm in any limb lead

|__| R > 11mm in AVL

|__| R in lead I plus S ≥ 25mm in lead III

Measured Voltage

*|__|__| R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages

*|__|__| S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages

R in V5 or V6-----S in V1 or V2

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

|__| R≥ 25mm

|__| S≥= 25mm

|__| R or S ≥ 30mm

|__| R + S ≥ 35mm

|__| Intrinsicoid deflection ≥ .05 sec

|__| ST depression

Hypertrophy, enlargement, and other ECG Diagnoses

(0=No, 1=Yes, 2=Maybe, 9=Paced or Unk)

|__| Nonspecific S-T segment abnormality

|__| Nonspecific T-wave abnormality

|__| U-wave present

|__| Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)

|__| RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)

|__| LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)

Comments and Diagnosis_____

_____

_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner -- Blood Pressure and Opinions in Interim

240313 FORM NUMBER **(SCREEN 13)**

|__|---- |__|__|__|	**2nd Examiner ID Number**	_____**2nd Examiner Last Name**

Second Examiner Blood Pressure (first reading)	**Systolic**	**Diastolic**	**Examiner ID**	
			Prefix	**ID**
	|__|__|__|	|__|__|__|	|__|	|__|__|__|
	to nearest 2 mm Hg	**to nearest 2 mm Hg**	**0=MD, 1=Other**	

Second Examiner Blood Pressure (second reading)	**Systolic**	**Diastolic**	**Examiner ID**	
			Prefix	**ID**
	|__|__|__|	|__|__|__|	|__|	|__|__|__|
	to nearest 2 mm Hg	**to nearest 2 mm Hg**	**0=MD, 1=Other**	

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner --Coronary Heart Disease Opinions in Interim

240314 FORM NUMBER (SCREEN 14)

|__| if yes, fill below	Chest Discomfort Characteristics (0=No, 1=Yes, 9=Unk)	
|__|__|*|__|__|	Date of onset	mo/yr,99/99=Unknown)
|__|__|__|	Usual duration	(minutes, 999=Unknown)
|__|__|__|	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
|__|	Location	(0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unknown)
|__|	Radiation	(0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)
|__|__|__|	Frequency (number in past month)	999=Unknown
|__|__|__|	Frequency (number in past year)	999=Unknown
|__|	Type	(1=Pressure,heavy,vise; 2=Sharp; 3=Dull; 4=Other; 9=Unk)
|__|	Relief by Nitroglycerine in <15 minutes	0=No
|__|	Relief by Rest in <15 minutes	1=Yes,
|__|	Relief Spontaneously in <15 minutes	8=Not tried
|__|	Relief by Other cause in <15 minutes	9=Unknown

Coronary Heart Disease Second Examiner Opinions		
|__|	Congestive Heart Failure	
|__|	Angina Pectoris	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Coronary Insufficiency	
|__|	Myocardial Infarct	

Comments about heart disease

_____

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EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner -- Syncope History in Interim

240315 FORM NUMBER **(SCREEN 15)**

|__| **Have you fainted or lost consciousness in the interim? (If due to stroke code as no and fill out stroke sheet) If event immediately preceded by head injury or accident code 0=No)**		**Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown**
if yes, fill all☞	|__|__|__|	**Number of episodes in the past two years**	**(999=Unknown)**
	|__|__|*|__|__|	**Date of first episode**	**(mo/yr, 99/99=Unknown)**
	|__|__|__|	**Usual duration of loss of consciousness**	**(minutes, 999=Unkn)**
if yes, fill all ☞	|__|__|	**Usual Activity Preceding Event (00=None, 01=Exertion, 02=Rest, 03=Defecation/Micturition/Cough, 04=Emotional upset, 05=Alcohol consumption, 06=Turning neck (e.g. shaving), 07=Postural change (e.g. lying to standing), 0 8=Recent medication change or ingestion, 09=Other, or combination (specify)_____, 10=Pain, 11 illness, specify_____99=Unknown)**	

	Symptoms noted before event(s) (0=No, 1=Yes, 2=Maybe, 9=Unkn)		Symptoms noted after event(s) (0=No, 1=Yes, 2=Maybe, 9=Unkn)
if yes, fill both columns to☞	|__|	**Nausea/vomiting**	|__| **Urinary/fecal incontinence**
	|__|	**Warning signs (e.g. Aura)**	|__| **Confusion**
	|__|	**Chest discomfort**	|__| **Focal weakness (e.g. arm,leg)**
	|__|	**Shortness of breath**	|__| **Other (specify)_____**
	|__|	**Palpitations**	_____

	|__|	**Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)**
if yes, fill☞	|__|	**Was event observed? (0=No, 1=Yes, 2=Maybe, 9=Unkn) Who observed event?_____**
	|__|	**ER/hospitalized or saw M.D. (0=No, 1=Hosp., 2=Saw M.D., 9=Unkn) Hospitalized at: _____**
			M.D. seen: _____

Syncope Second Opinions

|__| **Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)**

|__|	**Cardiac syncope**	**(0=No, 1=Yes, 2=Maybe, 9=Unknown)**
|__|	**Vasovagal syncope**	
|__|	**Other Specify:_____**	

|__| **Seizure Disorder (0=No,1=Yes, 2=Maybe,9=Unk)**

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner -- Cerebrovascular and Neurological History and Opinions

240316 FORM NUMBER (SCREEN 16)

Cerebrovascular Episodes in Interim		
|__|	Sudden muscular weakness	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Sudden speech difficulty	
|__|	Sudden visual defect	
|__|	Double vision	
|__|	Loss of vision in one eye	
|__|	Unconsciousness	
|__|	Numbness, tingling	
if yes, fill ☞ |__|	Numbness and tingling is positional	

Details for "Serious" Cerebrovascular Event in Interim		
|__|	Examiner's opinion that "serious" or "significant" cerebrovascular event took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
if yes or maybe fill all to ☞	|__|__|*|__|__|	Date (mo/yr,99/99=Unkn Observed by_____
	|__|	Onset time (1=Active, 2=During sleep, 3=While arising, 9=Unkn)
	|__|__|*|__|__|	Exact/approximate time (use 24-hour military time, 99.99=unkn)
	|__|__|*|__|__|*|__|__|	Duration (use format days/hours/mins, 99/99/99=Unknown)
	|__|	Hospitalized or saw M.D. 0=No,1=Hosp.2=Saw M.D,9=Unk
	|__|__|	Number of days stayed at _____

Stroke/TIA and Parkinson's Disease Second Opinions		
|__|	Stroke in Interim	
|__|	Transient Ischemic Attack in Interim (TIA)	(0=No,1=Yes,2=Maybe,9=Unknown)
|__|	Parkinsonism in Interim	
|__|	Other-- Specify:_____	

Comments about possible Cerebrovascular Disease

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_____

_____

EXAM 24 [_____] ID type/ID [_____]Last Name, First Name

Second Examiner --Peripheral Vascular History and Opinion

240317 FORM NUMBER (SCREEN 17)

Left	Right	Vascular symptoms (0=No, 1=Yes, 9=Unkn)
|__|	|__|	**Discomfort in calf while walking**
|__|	|__|	**Discomfort in lower extremity (not calf) while walking**
|__|		**Occurs with first steps**
|__|		**After walking a while**
|__|		**Related to rapidity of walking or steepness**
|__|		**Forced to stop walking**
|__|__|		**Time for discomfort to be relieved by stopping (minutes)** (00=No relief with stopping, 88=Not Applicable)
|__|__|		**Number of days/month of lower limb discomfort** (00=No, 88=N/A, 99=Unknown)

Intermittent Claudication Second Examiner Opinions	
|__|	**Intermittent Claudication** 0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

_____

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_____

Interim **Non Cardiovascular Diagnoses**		
|__|	Diabetes Mellitus	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Prostate Disease	
|__|	Emphysema	
|__|	**Chronic Bronchitis** (Cough that produces sputum at least 3 months in past 12 months)	
|__|	**Other non C-V diagnosis** (for cancer, see special screen)	

|0|	Non-physician Interview, offsite exam (1=Yes, 0=No)